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Sustainable Mental Health Provision Options in Zimbabwe: Insights from Non-Pharmacological Practitioners

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Abstract

Mental health service provision in Zimbabwe is currently under strain as it is not only largely unavailable but heavily relies on an unsustainable pharmacological approach which is understaffed and under-resourced. This study sought to gather insights from practitioners in the field of mental health on sustainable mental health options. The ultimate aim of this study was to come up with a sustainable model for mental health provision in the country. The researcher employed an explorative case study design in which 11 practitioners were purposively selected to take part in the study. The participants represented psychologists, clinical social workers and counsellors. This study revealed that there is no equilibrium between the demand for mental health services and the available services as very few mental health specialists and very few mental health centres are available in Zimbabwe. The study exposed the need for policy reformulation such that there is a focus and investment in non-pharmacological interventions which can be used alongside current pharmacological approaches. Non-pharmacological approaches are more sustainable as they are less expensive and largely available. There is a need for a multi-disciplinary approach to the provision of mental health as a team of professionals is more likely to offer effective treatment than just one specialist. The study proffered a model of mental health provision which is based on the integration of non-pharmacological interventions in primary health care facilities, schools and all public institutions.

Keywords: Non-pharmacological, sustainable mental health, integration, pharmacological.

Introduction

There is a surge in the need for mental health services globally and locally. This surge is partly due to the COVID-19 disturbances and also due to a rise in drug and substance misuse. There is therefore a greater need to explore viable and sustainable options for providing mental health care to all groups of people. The World Health Organisation (WHO, 2009)

defines mental health as "a state of well-being in which every individual realizes his or her potential, can cope with the normal stresses of life, can work productively and fruitfully, and can make a contribution to her or his community". Modern mental health provision was initiated at the beginning of the 20th century in the United States of America when Clifford Beers founded the first outpatient mental health clinic in 1908 (Peck, 2013). Traditionally, mentally ill persons were treated under strict institutionalisation in what were regarded as asylums. In those asylums, traditional treatments were well implemented: drugs were not used as a cure for a disease, but as a way to reset equilibrium in a person's body, along with other essential elements such as healthy diets, fresh air, middle-class culture, and the visits by their neighbouring residents (Novella, 2010). There was a transition from institutionalisation to trans-institutionalisation where patients were moved from one therapeutic centre to another either due to planned moves or unforeseen consequences.

The mid-20th century witnessed advocacy in favour of de-institutionalisation. De-institutionalisation is the process of replacing long-stay in psychiatric hospitals with less isolated community health services for those diagnosed with a mental disorder or developmental disability (Fakhourya & Priebe, 2007). Despite decades of promoting deinstitutionalization, mental health service delivery is still largely dominated by hospital care, which absorbs the largest proportion of the mental health budget, particularly in low and medium-income countries. There is an urgent need for a radical shift in the way mental disorders are managed, away from long-term institutionalization and towards community-based mental health care (WHO, 2013). It is the emphasis on community health services that gives relevance to non-pharmacological interventions as they present a more sustainable option for the provision of mental health. The other focus of the de-institutionalisation campaign was on reforming psychiatric care to reduce (or avoid encouraging) feelings of dependency, hopelessness and other behaviours that make it hard for patients to adjust to a life outside of care (Wright, 1997). What is clear therefore is that psychiatric drugs although very useful, are not sustainable in the long term as they encourage dependency and sometimes feelings of hopelessness. Moreover, for low-resourced countries such as Zimbabwe, reliance on psychiatric drugs is an economic strain. It is against this background that it becomes critical for governments to invest in non-pharmacological interventions as they can be provided within community settings which makes them much more sustainable. Non-pharmacological interventions include formal psychological therapies such as cognitive behaviour therapy (CBT) and interpersonal psychotherapy (IPT), as well as less formal supportive therapies such as counselling within primary care, mindfulness-based therapy, behavioural activation and self-help strategies. Lifestyle changes to improve diet, exercise, relaxation and sleeping habits should also be part of a broader management plan (Sarris, O'Neil, Coulson, Scweitzer & Berk, 2014). When properly implemented non-pharmacological interventions can effectively complement pharmacological interventions and as such provide a more

sustainable mental health system. Sustainability in mental health is the ability to provide high-value care now and in the future in the face of environmental, economic and social constraints (Community Research Connections, 2021).

Strong links exist between mental disorders and other chronic diseases such as heart disease, diabetes and HIV/AIDS, not just in terms of their common co-occurrence but also in terms of their underlying determinants and their public health consequences (WHO, 2014). The prevention and management of these chronic conditions can be enhanced by taking a more holistic, integrated and person-centred approach. Integrating mental health services into general, non-specialized health care is not only a sustainable option but a key strategy to expand coverage, and for the overall integration of services at the level of the healthcare system.

Zimbabwe has Four Public psychiatric referral centres: Ingutsheni Central Hospital, Harare Psychiatric Unit, Parirenyatwa Hospital Annexe and Ngomahuru Hospital. Two of these are in Harare. Bulawayo and Masvingo have one each. These do represent only three provinces in a country with ten provinces. The Medical and Dental Practitioners Council of Zimbabwe register (2021) has 19 registered psychiatrists in a country of 15 million people (according to the Worldometer) representing that there is one psychiatrist for about every 790 000 people. The few psychiatrists highlighted above are only available in Harare and Bulawayo meaning that the other eight provinces do not have psychiatrists. Psychiatrists are mental health specialists trained in the pharmacological treatment of mental illness.

It is also important to note that the four psychiatric centres available in the country are usually affected by the shortage of drugs, not to mention the unavailability of specialists (WHO, 2020). This unavailability of psychiatric drugs then pushes patients to purchase the drugs from private pharmaceuticals, which of course is expensive. This presents a very unsustainable mental health provision system. Zimbabwe does not have much in its system to support mental health besides the four major referral centres and a few school psychologists based at Provincial offices. The country also currently relies heavily on a pharmacological approach to mental health as there are no non-pharmacological specialists at primary health care facilities and very few to none at secondary and tertiary health care centres (WHO, 2020). Non-pharmacological specialists include psychologists, counsellors and clinical social workers. It is against this background that this study seeks to explore sustainable mental health provision options for a low income country such as Zimbabwe.

The specific objectives of this study were to:

1) Identify challenges in the current mental health system in Zimbabwe,
2) Explore non-pharmacological mental health options available in Zimbabwe,
3) Proffer a sustainable mental health provision model for Zimbabwe.

Methodology

Design

This study took a qualitative approach and employed the exploratory case study design. The explorative case study seeks to describe what exists and to observe and document aspects of a situation. It is used when there is no single set of outcomes, (Yin, 2014). This design was selected as there was no anticipated single set of outcomes when the research began. The design also enabled the researcher to appropriately capture in adequate detail the insights from practitioners regarding mental health provision in Zimbabwe.

Population and Sampling

The population for this study was all non-pharmacological mental health practitioners registered by the regulatory board in Zimbabwe which is the Allied Health Practitioners Council of Zimbabwe (AHPCZ). Practitioners targeted for this study were psychologists, clinical social workers and counsellors. According to the AHPCZ register (2021), there are 243 intern and fully registered psychologists, 273 counsellors and 29 clinical social workers. This makes a population total of 545. The researcher then used a purposive sampling technique to select practitioners from the three professions who gave their insights. The final sample included 11 practitioners, five were psychologists, four were counsellors and two were clinical social workers.

Data collection instrument

The researcher utilized in-depth interviews to collect rich and meaningful data from the practitioners. In-depth interviews were conducted through an online communication platform, Google-meet as it was difficult to meet the participants physically due to the COVID-19 restrictions as well as the long physical distances involved in contacting the practitioners physically.

Data Analysis

Thematic analysis was used to analyse data. Thematic analysis is a qualitative analysis method for identifying, analysing and reporting patterns within data (Braun & Clarke, 2006). It minimally organizes and describes data in rich detail. Some of the themes that emerged include the need for a multi-disciplinary approach, the absence of an efficient mental health system and non-pharmacological treatment options. Pseudonyms were used to protect the identity of the participants.

Results and Discussion

The results are presented under themes which emerged from the study. Findings were categorised under four themes which were (i) Challenges with the Zimbabwean mental health system, (ii) Non-pharmacological mental health options in Zimbabwe, (iii) Toward a multi-disciplinary approach to mental health and (iv) Sustainable mental health provision model. Direct quotations are used to accurately capture the insights of the respondents.

Challenges with the Zimbabwean Mental Health System

There is a rising demand for mental health services which is however not tallying with the available services. Zimbabwean public health facilities and generally most public facilities do not have non-pharmacological mental health

specialists such as psychologists and counsellors. A critical challenge that exists is therefore the scarcity of mental health specialists, both pharmacological and non-pharmacological. Participant 7 aptly put this as

> *"It would be difficult to even say we have a mental health system in this country, we have these things on paper but nothing much practical".*

Participant 2 said,

> *"The mental health system is strained, look at the number of substance abuse cases that we have versus practitioners who can assist…"*

These findings are in line with the WHO special initiative for mental health situational assessment report, (2020) which revealed that 'there is a lack of funding for medication, human resources, and mental health promotion in both psychiatric hospitals and community-based care.'

These findings also confirm Kohn's, (2004) findings that despite the ubiquity and prevalence of mental disorders, many countries have inadequate mental health systems and services. In most countries, especially those with low- and middle-income economies, there is an enormous gap between those who need mental health care, on one hand and those who receive care, on the other hand. Sexana, (2007) asserted that "fewer than 28% of countries have a specific budget for mental health care, and many countries face acute shortages of mental health workers". This goes on to show that the problem is not only local but global.

The lack of a multi-disciplinary approach was highlighted by participant 1,

> *"Currently, there is no multidisciplinary approach to mental health service provision with the government only supporting medical doctors and nurses in the provision of mental health services."*

Participant 10 explained the sidelining of non-pharmacological practitioners;

> *"Tertiary and provincial hospitals have intern psychologists who are currently offering mental health services under supervision as they are still in training. It is however unfortunate that despite the critical role played by the interns, they have not been receiving any monetary remuneration. This is despite the fact that their counterparts in other health fields such as nurses and radiographers get remunerated."*

Participant 9 revealed the lack of trained mental health practitioners at health institutions;

> *"There are only three fully trained psychologists in Zimbabwean tertiary hospitals and none at all at provincial and district hospitals. In the education system, psychologists are only found at provincial offices and none at the district level and public schools."*

These challenges are also highlighted in the WHO special initiative for mental health Zimbabwe situational assessment of 2020 which reported that Zimbabwe has a severe shortage of human resources for mental health, with an estimated 18 psychiatrists (17 of them in Harare) or approximately 0.1 per 100,000 population. There are 917 psychiatric nurses (6.5 per 100,000) and 6 psychologists (0.04 per 100,000). However, it is important to note that Zimbabwe has about 243 psychologists however almost all of them are not in the public mental health space due to unavailability of the posts in the Ministry of Health and Child Care structures.

Participant 8 commented on the lack of psychiatric drugs in hospitals,

"Locally psychotropic drugs are not being manufactured especially the newer drugs hence old type drugs with more side effects are used which increases poor adherence by clients."

Therefore reliance on a pharmacological approach becomes unsustainable since the drugs will not always be available.

Participant 10 commented on the lack of professionalism among some non-pharmacological practitioners;

"….I have sadly noted that the provision of mental health is not always professional and is mostly done by unqualified individuals who may cause harm to clients… some students are doing undergraduate degrees who are experimenting on people."

Such comments are indicative of a weak regulatory system in mental health practice. It appears the shortage of properly qualified specialists has created a vacuum for unqualified people to claim to offer mental health services.

Non-pharmacological mental health options in Zimbabwe

Non-pharmacological treatment plans can be used to complement pharmacological interventions. Such an approach presents a sustainable option for mental health provision in Zimbabwe as there are more non-pharmacological practitioners in the country and also because it is cost-effective in the long term. Participant 11 outlined the possible non-pharmacological treatments for mental illness which can be offered at low cost;

"Psycho-diagnosis and psychotherapy by psychologists; Occupational Therapy by occupational therapists, Counselling services by counsellors, who should refer difficult cases to psychologists, Community education by community Psychologists, who should work to prevent mental illness and educate communities on the need to seek the services of mental health professionals."

This was complemented by participant 2 who said;

"There is need for referral of patients with mental health problems, by medical practitioners, to mental health care professionals, for psychotherapy and counselling services"

Participant 7 highlighted the need for the establishment of special psychological rehabilitation institutions, such as Substance Use Rehabilitation Centres and Depression Treatment Centres for the management of mental illness. Participant 3 also explained the need for peer-to-peer support in communities where there are people who previously suffered from mental health conditions. Such people can offer knowledge on coping strategies to patients and caregivers alike.

These findings are in line with existing literature on what is currently happening in Zimbabwe regards psychotherapeutic services. The Friendship Bench for instance currently offers non-pharmacological mental health interventions at the community level in low-income areas of Zimbabwe. Their programme is lay counsellor-delivered problem-solving therapy for patients in primary care with depressive symptoms, (Community Mental Health, 2019). Their programme has demonstrated effectiveness and is currently being scaled up across primary health care facilities in Harare and other urban and rural areas in Zimbabwe. The WHO Special Initiative assessment report, (2020) revealed that some evidence-based psychosocial

interventions are offered at the few public specialist mental health facilities in Zimbabwe, though shortages in trained human resources and appropriate supervision structures limit service availability. The little work done in Zimbabwe with non-pharmacological options has shown that they present a sustainable alternative or option for prevention, treatment and management of mental health conditions.

Towards a multi-disciplinary approach to mental health

Findings from this study have revealed that there is a need to institute a multi-disciplinary approach to mental health if there is going to be the realisation of a sustainable mental health system in Zimbabwe. The multi-disciplinary team refers to members of different professions working together. There is a need to ensure that teams of mental health experts work together as colleagues to ensure the prevention and treatment of mental health conditions. Participant 5 commented on the need for a multi-disciplinary approach;

> *"A multidisciplinary approach is a very excellent way of dealing with mental health. There is a need to establish and strengthen a referral pathway so that patients may enjoy a comprehensive/ holistic package of care. Psychiatrists, Psychologists, Social workers, and Occupational therapists only to mention a few should be offering mental health. In schools, colleges, and universities there is a need to upscale mental health as there are a lot of suicide cases being reported. Every sector should have mental health services."*

These sentiments are supported by research, particularly Tyrer, (1998) who posits that the strength of multidisciplinary teams is that the combined expertise of a range of mental health professionals is used to deliver seamless, comprehensive care to the individual. The research evidence supports a multidisciplinary team working as the most effective means of delivering comprehensive mental health services to people with mental health problems, especially those with long-term mental health problems. According to Jefferies and Chan, (2004) multidisciplinary team working is described as the main mechanism to ensure truly holistic care for patients and seamless service for patients throughout their disease trajectory and across the boundaries of primary, secondary and tertiary care.

Sustainable mental health provisions model

A sustainable mental health provision model submitted here was informed by insights proffered by the practitioners.

There is an urgent need for policy reformulation such that mental health services are fully integrated within the primary health care system and public institutions. Primary health care is the foundation for high-quality and sustainable mental health care. According to WHO, (2009), mental health services integrated into primary care include the identification and treatment of mental disorders, referral to other levels where required, attention to the mental health needs of people with physical health problems, and mental health promotion and prevention. Where mental health is integrated into primary care, access is improved, mental disorders are more likely to be identified and treated, and comorbid physical and mental health problems are managed seamlessly.

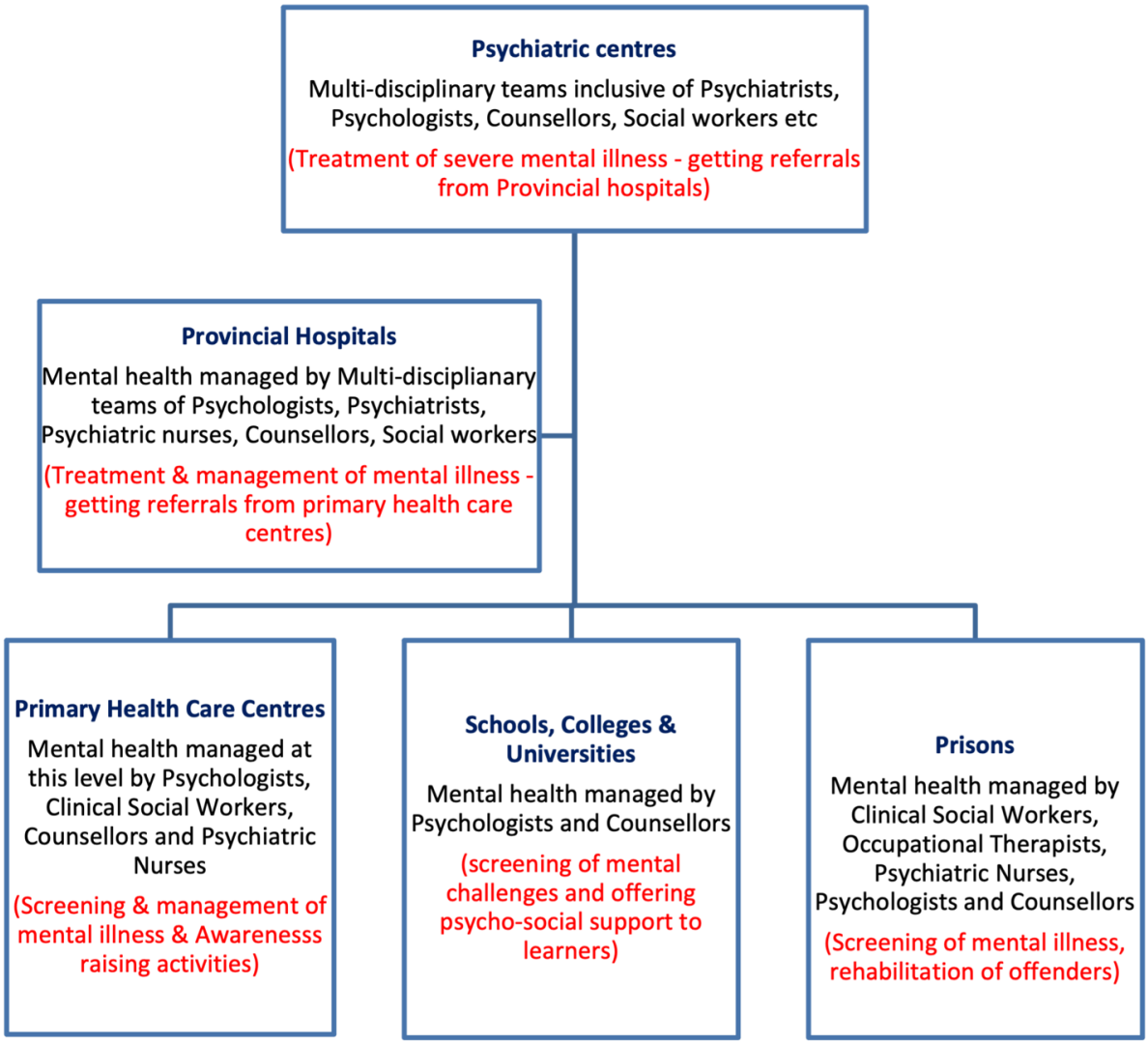

Figure 1: Chart showing the sustainable mental health provision model

To be fully effective and efficient, primary mental health care must be complemented by additional levels of care, (WHO, 2009). These include secondary care components to which primary health workers can turn for referrals, support, and supervision. Linkages to informal and community-based services also are necessary. This integration will entail that the training of counsellors and psychologists is embedded in the health system. The students should be part of the system and should get paid during training. Fully trained psychologists should be engaged in all health care facilities and public institutions to offer training and mental health services. Besides health care facilities, psychologists, clinical social workers and counsellors should be engaged in public schools, district education offices, prisons, colleges and other public institutions.

The government should invest in non-pharmacological mental health service provision. This will be done partly by

employing psychologists and counsellors within the primary health care system and public institutions. There should also be serious investment in tools of the trade such as psychometric instruments which are necessary for screening and diagnosis of mental disorders.

This model also posits that the government should absorb clinical and counselling psychology interns into the health sector as a matter of urgency. The proposal is that every Psychiatric Hospital should have at least ten (10) interns, every Provincial Hospital to have at least five (5) interns and at least one intern psychologist for every District Hospital. This arrangement will entail the engagement of fully registered psychologists at all the stated hospitals to ensure proper supervision of the interns.

The school system represents a greater chunk of the population of Zimbabwe. In that regard, it is necessary to ensure that educational psychologists are engaged at every public school. Currently, only private schools are engaging psychologists in their schools and public schools access psychologists at the provincial level.

Registration and compliance of mental health practitioners are critical as it ensures that only properly qualified people are engaged to offer mental health services. This arrangement ensures that the mental health of members of the public is protected from charlatans and persons of dubious qualifications who may end up hurting instead of healing clients. The emphasis on professionalism is a key issue that arose from the findings of this study and as such, it is necessary that regulatory bodies should monitor those who offer mental services.

There is a need to raise awareness of the causes and treatment of mental illnesses to deal with the stigma currently associated with mental illnesses in our communities. This will need the full engagement of psychologists, counsellors and social workers.

The integration of non-pharmacological mental health options in primary health care facilities in a sustainable approach to the prevention, treatment and management of mental illness as these primary health care facilities are within reach of most people. Moreover, currently, there is a relatively high number of non-pharmacological practitioners who are fully trained and some still under training who can provide the services. The availability of these practitioners entails that the approach will be sustainable.

Conclusion

This study revealed that there are many challenges with the Zimbabwean mental health system. Participants revealed many non-pharmacological options that can be pursued in the Zimbabwean context. The options provided pointed towards a multi-disciplinary approach to mental health and a sustainable mental health provision model.

The Zimbabwean mental health system is currently unsustainable as it is relying on a poorly resourced pharmacological approach hinged on only four psychiatric centres and very few psychiatrists and psychiatric nurses. The system currently does not seem to give any serious recognition to non-pharmacological practitioners who include psychologists, counsellors and clinical social workers.

A sustainable approach to the provision of mental health entails the

engagement of treatment plans that are affordable to the government. Currently, there is an over-reliance on pharmacological treatment plans which are not only largely unavailable to the majority of citizens but also too expensive to both the government and individuals. There is therefore a need for policy reformulation so that there can be a focus and an investment in non-pharmacological treatment options. These non-pharmacological interventions would need to be integrated within the primary health care system which is available to the majority of the people. To enhance the sustainability of this approach, there will be a need to adopt a multi-disciplinary approach to the treatment of mental illness.

There is a need to ensure that counsellors and psychologists are available at the school level. That will guarantee the sustainability of mental health services in the school system to which almost all children belong. Overall there is a need to ensure that mental health provision is pervasive in all public institutions. There should be clear screening and treatment platforms at all primary health care centres.

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